

FOR STATE
HEALTH DEPT.

00820

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00820

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Md.		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Dwayne Beck		4. DATE OF DEATH Month 1 Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1962
9. AGE (In years last birthday) yrs. 4		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A.	
13. FATHER'S NAME Clarence Beck		14. MOTHER'S MAIDEN NAME Dorothy Tilghman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy Tilghman		Address R.F.D. #1 Rock Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 916.0 Burned to death in house fire IMMEDIATE CAUSE (a) Multiple severe Burns DUE TO (b) Blood drawn for carbon monoxide DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH short
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) See above, Was alone in house with 2 siblings	
20c. TIME OF INJURY Month, Day, Year 11-12 a.m. 1/14 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home	20f. (City or town) (County) (State) Rock Hall (rural) Kent, Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert R. Farr M.O.		22. DATE SIGNED 1/16/67	
EXAMINER'S NAME (Type) Robert R. Farr M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/1967	23c. NAME OF CEMETERY OR CREMATORY Aaron Chaple Cem	23d. LOCATION (City or Town) (County) (State) R.F.D. Rock Hall Kent Md.
24. FUNERAL DIRECTOR Samuel W. Wally		25a. REC'D BY REGISTRAR DATE JAN 19 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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00820

FOR STATE
HEALTH DEPT.

00821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00821

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Md.		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Linda Beck		4. DATE OF DEATH Month 1 Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/8/1964
9. AGE (In years lost birthday) yrs. 2		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Beck		14. MOTHER'S MAIDEN NAME Dorothy Tilghman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy Tilghman		Address R.F.D.#1 Rock Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 9/16/0 IMMEDIATE CAUSE (a) Multiple Severe Burns DUE TO Burned to death in house fire, while alone (b) there with 2 siblings DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH short	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) see above	
20c. TIME OF INJURY Month, Day, Year 1-12 our a.m. 1/14/67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, etc.) home		20f. (City or town) (County) (State) (Rural) Rock Hall, Kent, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE R. R. Farr		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Robert R. Farr M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 1/16/67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/1967	23c. NAME OF CEMETERY OR CREMATORY Aaron Chaple Cem.	23d. LOCATION (City or Town) (County) (State) R.F.D. Rock Hall, Kent, Md.
24. FUNERAL DIRECTOR Kenneth W. Wally		25a. REC'D BY REGISTRAR DATE JAN 19 1967	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00821

00821

FOR STATE
HEALTH DEPT.

00822

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00822

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Md.		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		d. STREET ADDRESS R.F.D.#1 Rock Hall, Maryland 14.1	
3. NAME OF DECEASED (Type or print) Monique First Middle Last Beck		4. DATE OF DEATH Month 1 Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/27/1963
9. AGE (In years lost, birthday) yrs. 3		IF UNDER 1 YEAR Months 1 Days 14 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Clarence Beck		14. MOTHER'S MAIDEN NAME Dorothy Tilghman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Dorothy Tilghman		Address R.F.D.#1 Rock Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Severe Burns DUE TO (b) Burned to death in fire, while alone at home with 2 siblings DUE TO (c) 916.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN DEATH AND DEATH Short
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) see above	
20c. TIME OF INJURY Month, Day, Year 11-12 a.m. 1/14/67	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home (rural) Rock Hall, Kent, Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Robert R. Farr M.D.		22. DATE SIGNED 1/16/67	
EXAMINER'S NAME (Type) Robert R. Farr M.D.		Address (Street, city, town, or county) Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/17/1967	23c. NAME OF CEMETERY OR CREMATORY Aaron Chaple Cem.	23d. LOCATION (City or Town) (County) (State) R.F.D. Rock Hall, Kent Md.
24. FUNERAL DIRECTOR Smith		25a. REC'D BY REGISTRAR DATE JAN 19 1967	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00823

CERTIFICATE OF DEATH

00823

1. PLACE OF DEATH o. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 3 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		d. STREET ADDRESS 118 North Queen Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Elsie Mae Brown		4. DATE OF DEATH Month Day Year Jan. 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-11-1897
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Clerk		10b. KIND OF BUSINESS OR INDUSTRY EX Telephone Co.	
11. BIRTHPLACE (County & State, or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Joseph Gordon (D)		14. MOTHER'S MAIDEN NAME Ludella Eshan (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 221-16-6569	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMATOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) ADENOCARCINOMA OF ENDOMETRIUM DUE TO (c) LEUKEMIA			INTERVAL BETWEEN ONSET AND DEATH 2 YR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-28 , 19 66 , to 1-14 , 19 67 , that (I) (we) last saw the deceased alive on 1-14 , 19 67 , and that death occurred at 4:20 P.M., from causes on and on the date stated above.			
22a. SIGNATURE Harry Paul Ross		22b. DATE SIGNED 1-14-67	
22c. PHYSICIAN'S NAME (Type) Dr. Harry Paul Ross		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Arlington Cem.	23d. LOCATION (City or town) (County) (State) Phila Pa
24. FUNERAL DIRECTOR H. Peter Daniels - Middletown, Del		25a. REC'D BY REGISTRAR JAN 18 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

45200

6320

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH												
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
00824					MEDICAL EXAMINER'S CERTIFICATE OF DEATH					00824		
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sharptown					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS Sharptown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John			First H. Middle Butler Last			4. DATE OF DEATH Jan. 12 19 67		Month 12 Day 19 Year 67				
5. SEX male		6. COLOR OR RACE col		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/18/1890		9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 7 Days 14 Hours 14 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY yard man		11. BIRTHPLACE (State or foreign country) St. Marys County			12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME James Butler						14. MOTHER'S MAIDEN NAME Catherine Johnson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217 54 5321		17. INFORMANT Edward Parker			Address Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Was visiting sister and fell dead at her home. DUE TO (c) home.										INTERVAL BETWEEN ONSET AND DEATH unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Robert W. Farr, M. D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22. DATE SIGNED 1/14/67			
EXAMINER'S NAME (Type) Robert W. Farr, M. D.						M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county)												
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORY Sharptown cemetery			23d. LOCATION (City, town or county) (State) Rock Hall Kent Md.			
24. FUNERAL DIRECTOR Marvin V. Williams						ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR JAN 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TECHNICAL EXAMINER'S CERTIFICATE OF DEATH

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00825

CERTIFICATE OF DEATH

00825

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN 1b 46 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown d. STREET ADDRESS Rt. #1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nellie Middle Pauline Last Coleman			4. DATE OF DEATH Month 1 Day 13 Year 19 67				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/4/17		9. AGE (In years last birthday) 49 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kent Co. Health Dept.		10b. KIND OF BUSINESS OR INDUSTRY R. N.		11. BIRTHPLACE (County & State, or foreign country) Kent Co., Maryland			
13. FATHER'S NAME Willaim Ray Crew			14. MOTHER'S MAIDEN NAME Hattye NMN Boone				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 26 3677		17. INFORMANT Hospital Records Address Chestertown, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatous DUE TO (b) Carcinoma of breast DUE TO (c) 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 11/28 , 19 66 , to 1/13 , 19 67 , that (I) (we) last saw the deceased alive on 1/13 , 19 67 , and that death occurred at 12:35 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Dr. R. W. Farr		22b. DATE SIGNED 1-15-67		22c. PHYSICIAN'S NAME (Type) Dr. R. W. Farr			
22d. ADDRESS Chestertown, Maryland		22e. REC'D BY REGISTRAR JAN 18 1967					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/16/67		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery			
23d. LOCATION (City or Town) Chestertown, Md.		23e. REGISTRAR'S SIGNATURE James Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00826

CERTIFICATE OF DEATH

00826

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Queen Anne's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. LENGTH OF STAY IN lb <u>1 day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Church Hill</u> <u>17-2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kent-Queen Anne's Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Harvey</u> Last <u>Dew</u>				4. DATE OF DEATH Month <u>1</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-7-1888</u>	9. AGE (In years last birthday) yrs. <u>78</u>	IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>2</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>VARIOUS</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMER</u>	
13. FATHER'S NAME <u>Rullen Dew</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-03-0385</u>		17. INFORMANT Address <u>Hospital Records Chestertown</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>493X</u> IMMEDIATE CAUSE (a) <u>Pneumonia,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Mycarditis, chronic due to arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1</u> , 19 <u>67</u> , to <u>1-2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1-2</u> , 19 <u>67</u> , and that death occurred at <u>1230</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>A.C. Dick</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1-2-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				22d. ADDRESS <u>Chestertown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/7/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BETHEL CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>CHURCH HILL, Q.A. MD</u>	
24. FUNERAL DIRECTOR <u>Kenneth Walley</u>				ADDRESS <u>Chestertown, Md</u>		25a. REC'D BY REGISTRAR DATE <u>AN 9</u> 19 <u>67</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00827						00827					
1. PLACE OF DEATH a. COUNTY Kent County, Maryland						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Md.						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D. Rock Hall, Maryland					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) First Middle Last Bertie Groce						4. DATE OF DEATH Month Day Year 1 2 1967					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/15/1875		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (County & State, or foreign country) Kent County, Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Daniel Bulter						14. MOTHER'S MAIDEN NAME France Thompson					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. —		17. INFORMANT Mr. Murrill Groce		Address R.F.D. #1 Rock Hall, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Cardiac Vascular DUE TO (c) Cerebral accident PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from Jan 1, 1965, to 1-2-1967, that (I) (we) last saw the deceased alive on Jan 2, 1967, and that death occurred at 8 AM, from the causes and on the date stated above.											
22a. SIGNATURE Norbert C. Nitsch						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1/5/67		
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch M.D.						22d. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1/5/1967		23c. NAME OF CEMETERY OR CREMATORY Aaron Chaple Cem.			23d. LOCATION (City, town or county) (State) R.F.D. Rock Hall, Md.			
24. FUNERAL DIRECTOR C. Emmett Webb						ADDRESS Chestertown, Md.			25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Charles Judge		

JAN 9 1967

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James W. [Signature]

FOR STATE
HEALTH DEPT.

00828

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00828

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Worton, Md.		c. LENGTH OF STAY IN 1b Lifetime	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R.F.D. Worton, Maryland		d. STREET ADDRESS At Home	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Abbie		4. DATE OF DEATH Month 1 Day 27 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/27/1890
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 7 Days 7 Hours 7 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Various	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Turner		14. MOTHER'S MAIDEN NAME CARRIE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-16-9886	
17. INFORMANT Mrs. Carrie Worton		Address R.F.D. Worton, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4330 DUE TO (b) Manner of death resembled that due to cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO (c) arrest due to unknown cause.		INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Robert W. Farr		22. DATE SIGNED 1/31/67	
EXAMINER'S NAME (Type) Dr. Robert W. Farr M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Chestertown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/31/1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City or Town) (County) (State) R.F.D. Worton Kent Md.
24. FUNERAL DIRECTOR Charles Judge		25a. REC'D BY REGISTRAR DATE FEB 3 1967	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Case 6

2000-11-10

10/10/00

Handwritten notes and stamps, including a date stamp "10/10/00" and a signature.

FOR STATE
HEALTH DEPT.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00829

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00829

1. PLACE OF DEATH a. COUNTY Kent		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown		c. LENGTH OF STAY IN 1b lifetime	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Erwin Middle Walter Last Landwehr		4. DATE OF DEATH Month 1 Day 10 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 11, 1933
9. AGE (in years last birthday) 33 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Mins. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - furniture		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Kent Co., Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Landwehr		14. MOTHER'S MAIDEN NAME Edith Meekins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 220 28 4322	
17. INFORMANT Jane Dawkins Landwehr		Address Worton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation DUE TO Was found between front seats of closed panel truck with face close to tank of propane gas which had been turned on. Tank was empty. (b) Asphyxiation DUE TO Asphyxiation (c) Asphyxiation			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) See above	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Robert W. Farr</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr, M. D.		22. DATE SIGNED 1/11/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/13/67	23c. NAME OF CEMETERY OR CREMATORY Chester Cem.
23d. LOCATION (City, town or county) (State) Chestertown Md.			
24. FUNERAL DIRECTOR J. Willis Wells		ADDRESS Chestertown, Md.	
25a. REC'D BY REGISTRAR JAN 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

Page 1

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MEDICAL EXAMINERS' CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00830

00830

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Rock Hall (25 yrs.) d. STREET ADDRESS Sunnyland Farm e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ARTHUR Middle ALLAN Last MITTEN				4. DATE OF DEATH Month Jan. Day 19 Year 1967			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 29, 1888	
9. AGE (In years last birthday) 78		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Dr. & Phila Transit Co.		11. BIRTHPLACE (State or foreign country) Attica, Ind.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas E. Mitten				14. MOTHER'S MAIDEN NAME Katherine Warner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW 1 160 01 3319		17. INFORMANT Gertrude Mitten Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 4330 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO Manner of death suggestive of cardiac arrest. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH short	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert W. Farr				22. DATE SIGNED 1/20/67			
EXAMINER'S NAME (Type) Robert W. Farr				Address (Street, city, town, or county) Chestertown Kent Co. Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/21/67		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION (City, town or county) (State) Rock Hall, Md.	
24. FUNERAL DIRECTOR J. Willis Wells				25a. REC'D BY REGISTRAR JAN 23 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown c. LENGTH OF STAY IN 1b adult life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) At home, Lankford Bay Estates					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown d. STREET ADDRESS Lankford Bay Estates e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) James Bayard Newnam					4. DATE OF DEATH Jan. 8 19 67				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 11, 1895		9. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME James B. Newnam, Sr.					14. MOTHER'S MAIDEN NAME Miriam Walraven				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no (If yes give war or dates of service)					16. SOCIAL SECURITY NO. 220 36 9120		17. INFORMANT Miriam Walraven Address Wife Vera S. Newnam		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: Arteriosclerotic cardiovascular disease IMMEDIATE CAUSE (a) 422.1 DUE TO (b) Had been in good health. Was found dead in bed about 6:00 A.M. Jan. 8, 1967. DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Robert W. Farr, M. D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22. DATE SIGNED 1/10/67	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/10/67		23c. NAME OF CEMETERY OR CREMATORY Crumpton Cemetery		23d. LOCATION (City, town or county) (State) Crumpton, Md.			
24. FUNERAL DIRECTOR J. Willis Wells				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR J. Charles Judge		25b. REGISTRAR'S SIGNATURE	
				DATE JAN 11 1967					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

00832

CERTIFICATE OF DEATH

00832

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 9 1/2 hrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Millington 17.2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Anne's Hospital		d. STREET ADDRESS None	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Mary Mabel Phillips		4. DATE OF DEATH Month Day Year 1 4 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-14-1897
9. AGE (In years lost birthday) yrs. 69		10. IF UNDER 1 YEAR Months Days Hours Min. 69	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? US		13. FATHER'S NAME Albert Dunn	
14. MOTHER'S MAIDEN NAME Mary Lou Bell		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 212-40-9358		17. INFORMANT Hospital Records Address Chestertown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage & quadriplegia DUE TO 422.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) A.S.C.U.D DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 7 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/3 , 1967, to 1/4 , 1967, that (I) (we) last saw the deceased alive on 1/4 , 1967, and that death occurred at 1/4 M, from causes and on the date stated above.			
22a. SIGNATURE H. P. Ross		22b. DATE SIGNED 1-4-67	
22c. PHYSICIAN'S NAME (Type) Dr. H. P. Ross		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 6, 1967	23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery	23d. LOCATION (City or Town) (County) (State) Sudlersville, Md.
24. FUNERAL DIRECTOR Edward Fellows,		25a. REC'D BY REGISTRAR DATE JAN 6 1967	
ADDRESS Millington, Md. 21651		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

32300

9302

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00833						00833					
1. PLACE OF DEATH a. COUNTY KENT MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall				14.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY First ELIZABETH Middle Price Last						4. DATE OF DEATH JAN. Month 8 Day 19 Year 67					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 3 - 1878		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY x		11. BIRTHPLACE (County & State, or foreign country) Cecil Co. MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME THOMAS FORD						14. MOTHER'S MAIDEN NAME MARY E. MOORE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 217-30-7608		17. INFORMANT Address MRS. HESTER WILSON - FAIRLEE MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Cardio Vascular DUE TO (c) C.A. Spina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 67 , to Jan 8 , 19 67 , that (I) (we) last saw the deceased alive on Jan 7 , 19 67 , and that death occurred at 10 AM , from the causes and on the date stated above.											
22a. SIGNATURE Norbert C. Nitsch						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-9-67			
22c. PHYSICIAN'S NAME (Type) NORBERT C. NITSCH						22d. ADDRESS Rock Hall MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JAN. 11		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall MD.					
24. FUNERAL DIRECTOR Edgar L. Lane				ADDRESS Church Hill MD.		25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge			

00833

CERTIFICATE OF DEATH

00833

Rock Hall
 Mary
 Rock Hall
 Mary
 Rock Hall
 Mary

Female
 Housewife
 Thomas Ford
 Mary E. Moore
 17-28-1888
 10-12-1888

Quincy, Ill.
 C. A. Moore
 C. A. Moore

Rock Hall
 Mary
 Rock Hall
 Mary
 Rock Hall
 Mary

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
00834 CERTIFICATE OF DEATH 00834											
1. PLACE OF DEATH a. COUNTY Kent County, Maryland MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D.# Chestertown, Md.				c. LENGTH OF STAY IN 1b 20 Yrs.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) R.F.D.# Chestertown, Maryland 14.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) At Home						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Blanche Middle Alma Last Ringgold						4. DATE OF DEATH Month 1 Day 21 Year 1967					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/11/1898		9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Teacher				10b. KIND OF BUSINESS OR INDUSTRY Teacher		11. BIRTHPLACE (County & State, or foreign country) Va.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Watkins						14. MOTHER'S MAIDEN NAME Victoria Unk.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 083-16-3885		17. INFORMANT Mr. Ernest Ringgold				Address Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Cardiovascular disease DUE TO (c) Hypertension										INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-12-1963 to 12-28 , 19 67 , that (I) (we) last saw the deceased alive on 12-28 19 64 , and that death occurred at 12:20 PM from the causes and on the date stated above.											
22a. SIGNATURE Rudolf Eglitis						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) Rudolf Eglitis M.D.						22d. ADDRESS Rock Hall, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 1/26/1967		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery			23d. LOCATION (City, town or county) (State) R.F.D. Chestertown, Md.		
24. FUNERAL DIRECTOR Charles Judge						ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR JAN 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00034

00034

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00835

CERTIFICATE OF DEATH

00835

1. PLACE OF DEATH a. COUNTY Kent County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent County	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY in 1b Life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes Hospital		d. STREET ADDRESS Box 85 Route #2	
3. NAME OF DECEASED (Type or print) First Esther Middle ? Last Stewart		4. DATE OF DEATH Month 1 - Day 28 Year 19 67	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/1914
9. AGE (In years last birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 14 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Housework		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Coleman, Kent Co, Maryland		12. CITIZEN OF WHAT COUNTRY? Ame.	
13. FATHER'S NAME James ?NMN Moody		14. MOTHER'S MAIDEN NAME Martha ?NMN White	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. yes 2-15-18-4499	
17. INFORMANT Burnice Stewart		Address Worton, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) 1			INTERVAL BETWEEN ONSET AND DEATH 2 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1-26 , 19 67 , to 1-28 , 19 67 , that (I) (we) last saw the deceased alive on 1-28 19 67 , and that death occurred at 8:30 P.M. from causes and on the date stated above.			
22a. SIGNATURE A.C. Dick M.D.		22b. DATE SIGNED 1-28-67	
22c. PHYSICIAN'S NAME (Type) A.C. Dick M.D.		22d. ADDRESS Chestertown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 1/4/1967	23c. NAME OF CEMETERY OR CREMATORY Union Methodist Cem.	23d. LOCATION (City or Town) (County) (State) R. F. D. Worton Kent Md.
24. FUNERAL DIRECTOR Bennett		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE FEB 3 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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00835

Kent County

Chatterton

Kent + Queen Anne's Hospital

Eather

Female Negro

General Hospital

James 3mm Meddy

No

Maryland

Porton

Box 85 Route #2

Stewart

6/11/41 25

Coleman, Kent, Maryland

Martha 3mm White

00835

Kent County

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #8 File #6385 2/20/67 pc

00836

CERTIFICATE OF DEATH

00836

1. PLACE OF DEATH a. COUNTY Kent			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kennedyville		c. LENGTH OF STAY IN lb 1-21 1-28		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kenedyville,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) The Kent & Queen Anne Hospital			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Louis Garfield Wilson			4. DATE OF DEATH Month Day Year January 28 1967		
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-27-1891/ 1890 76		9. AGE (in years last birthday) yrs. 28 1967
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY FACTORY		11. BIRTHPLACE (County & State, or foreign country) Kent, Chesterville, Md	
12. CITIZEN OF WHAT COUNTRY? U. S. A			13. FATHER'S NAME John Wilson		
14. MOTHER'S MAIDEN NAME Jannie Brown			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.I		
16. SOCIAL SECURITY NO. YES			17. INFORMANT Miss. Olivia Wilson		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis DUE TO Cerebral arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332X (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia due to BPH. Senility			INTERVAL BETWEEN ONSET AND DEATH years		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I) (this hospital) attended the deceased from 21 Jan, 1967 , to 28 Jan, 1967 that (I) (we) last saw the deceased alive on 28 Jan 1967 , and that death occurred at 4 am , from causes and on the date stated above.		
22a. SIGNATURE Wallace Obenshain			22b. DATE SIGNED 30 Jan 67		
22c. PHYSICIAN'S NAME (Type) Wallace Obenshain M.D.			22d. ADDRESS Cecilton, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/4/1967		23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	
23d. LOCATION (City or Town) (County) (State) Millington Kent Md.		24. FUNERAL DIRECTOR Kenneth Walby		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE FEB 7 1967		25d. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

00830

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1. The...